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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMES C. ARTHUR** **905 Summit Drive** **Wexford, PA 15090** **Registered Nurse License No. 590524** Respondent.	Case No. 2013-351 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 30, 2001, the Board of Registered Nursing issued Registered Nurse License Number 590524 to James C. Arthur ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on May 31, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 118, subdivision (b) of the Code provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

5. Section 2750 of the Code provides that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

6. Section 2764 of the Code provides that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

7. Under section 2811, subdivision (b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

8. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . . .

"(4) Denial of licensure, . . . or any other disciplinary action against a health care professional license or certificate by another state . . . of the United States, [or] by any other government agency . . . ."

9. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . . .

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug . . . as defined in Section 4022, . . . to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section [i.e., controlled substances as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined by Code section 4022]."

10. Section 4022 of the Code defines "dangerous drug" as "any drug . . . unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

. . . .

"(c) Any other drug . . . that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1442 defines the legal term "gross negligence," as used in Code section 2761, as including "an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required . . . which the nurse knew, or should have known, could have jeopardized the client's health or life."

12. California Code of Regulations, title 16, section 1443 defines the legal term "incompetence," as used in Code section 2761, as "the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

13. California Code of Regulations, title 16, section 1443.5 states, in pertinent part:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

. . . .

"(3) Performs skills essential to the kind of nursing action to be taken . . . ."

14. California Code of Regulations, title 16, section 1444 states, in pertinent part:

"A[n] . . . act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such . . . acts shall include but not be limited to the following:

"(a) Assaultive or abusive conduct . . . .

. . . .

"(c) [D]ishonesty, fraud, or deceit."

REASONABLE COSTS

15. Section 125.3 of the Code provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES

16. Marijuana is a Schedule I controlled substance as designated by Health and Safety Code section 11054, subdivision (d)(13), and is categorized as a dangerous drug pursuant to Code section 4022.

17. Dilaudid is a trade name for Hydromorphone, which is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J), and is categorized as a dangerous drug pursuant to Code section 4022.

18. Fentanyl is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(8), and is categorized as a dangerous drug pursuant to Code section 4022.

19. Clonazepam is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(7), and is categorized as a dangerous drug pursuant to Code section 4022.

20. Ambien is a trade name for Zolpidem, which is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(32), and is categorized as a dangerous drug pursuant to Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence)

21. Respondent is subject to disciplinary action under Code sections 2750 and 2761, subdivision (a)(1), in that Respondent engaged in gross negligence and/or incompetence. The circumstances are as follows:

a. On or about March 26, March 28 and/or March 29, 2010, while Respondent was working as a registry or travel nurse at Mission Hills Hospital in Laguna Beach (MHLB), Respondent stashed the patient's day-shift medications in the patient's ICU bed-side stand, even though he falsely documented giving the medication on the Medication Administration Record (MAR), in violation of MHLB's Hospital Procedure 1.7, which requires medications not administered to a patient to be returned to the Medstation as soon as possible and pursuant to hospital protocol specified in Procedure 1.7.

b. On or about March 29 or March 30, 2010, while Respondent was working at MHLB, Respondent initialed two MARs regarding ICU patient 316 and the medications of Nystatin, Nitroglycerin and Hydromorphone (Dilaudid), but failed to sign the MARs.

c. On or about March 28, 2010, while Respondent was working at MHLB, Respondent gave post-operation ICU patient-316 doses of Dilaudid at different times, but made the following documentation errors:

i. For the entire shift, Respondent failed to record the patient's vitals signs.

ii. Respondent did not indicate the IVF (i.e., Intravenous Fluid).

iii. Respondent left the "I & O" (i.e., input and output) blank, and did not tally the Intake and Output data on the patient.

iv. Respondent's documentation regarding his notes was inadequate, merely noting that the patient was asleep or waking up with pain, and the medicating of the patient.

d. On or about April 6, 2010, while Respondent was working as a travel nurse for the Clinical Staffing Services (CSS) nursing registry and while Respondent was at Saddleback Memorial Medical Center (SMMC) in San Clemente, California, Respondent untimely and improperly wasted a narcotic, in violation of SMMC's policy, protocol and/or procedure. Respondent removed medications at about 2100 (i.e., 9 p.m.), but did not waste the medication until 0700 (i.e., 7 a.m.) the next day, April 7.

e. On or about March 9 and 10, 2011, while Respondent was working as a registry nurse during the night shift at Hollywood Presbyterian Medical Center (HPMC), Respondent engaged in the following gross negligence and/or incompetence:

i. Respondent administered Dilaudid on a patient at 2015 or 2020 (i.e.., 8:15 or 8:20 p.m.), contrary to doctor's order[s] discontinuing any administration of the narcotic as of 1930 (i.e., 7:30 p.m.).

ii. Respondent engaged in improper pre-documentation on a patient, with check off and timing after 2330 (i.e., 11:30 p.m.), even though Respondent left at approximately 2300 (i.e., 11 p.m.) hours. Respondent documented the Nursing Care flow sheet in advance as follows:

A. Under the heading "Hygiene," Respondent documented that he provided back care and hair care at 0400 (4 a.m.) hours.

B. Under the heading "Activity," Respondent documented that he provided "dangle" and "OOB [i.e., out of bed] in Chair" at 0200 (2 a.m.) hours to a bedridden patient unable to get out of bed, and that he turned the patient at 0200 hours, 0400 hours and 0600 (i.e., 6 a.m.) hours.

iii. Respondent failed to implement physician's orders by not sending a patient's specimens to the laboratory.

iv. Respondent failed to document in the patient chart any complaint of patient pain, the administration of 1 milligram of Dilaudid, which was documented in the MAR, and the follow-up assessment of the patient after the administration of the Dilaudid.

v. Respondent erroneously documented on the Nursing Care flow sheet that a supra-pubic tube was on one patient, a female patient with MR 11182322 when it was on another patient, a male patient with MR 00485207.

vi. On the Nurses Notes, Respondent's first and only entry was at 2030 (i.e., 8:30 p.m.) hours, approximately one hour late.

SECOND CAUSE FOR DISCIPLINE

(Use of Controlled Substances While on Duty)

22. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (b), in that Respondent used controlled substances while on duty as a registered nurse. The circumstances are as follows:

a. On or about November 14, 2010, while employed as a registry nurse by Supplemental Health Care and while on duty at Providence Little Company of Mary hospital in Torrance (LCM), Respondent smoked marijuana, a controlled substance that he had a prescription for, in his car, and some sort of pill. After he returned to his work area, his breath smelled of marijuana, notwithstanding the fact that a urine sample collected soon afterward the same day resulted in a negative drug test.

THIRD CAUSE FOR DISCIPLINE

(False, Incorrect or Inconsistent Medical Documentation)

23. Respondent is subject to disciplinary action under Code sections 2750 and 2762, subdivision (e), in that Respondent's medical documentation was false, grossly incorrect and/or grossly inconsistent. Complainant refers to and incorporates all the allegations contained in paragraph 21 above, subparagraphs (a), (c)(i) through (c)(i) and (e)(vi), inclusive, as though set forth fully.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

24. Respondent is subject to disciplinary action under Code sections 2750 and 2761, subdivision (a), in that Respondent engaged in unprofessional conduct. The circumstances are as follows:

a. On or about March 26, March 28 or March 29, 2010, while Respondent was working at MHLB, he caused a critically ill ICU patient to be fearful by telling the patient, "I'm going to be real sure that you are very well sedated tonight."

b. On or about March 26, March 28 or March 29, 2010, while Respondent was working at MHLB, he made frequent inappropriate comments to staff, including the nursing supervisor, including statements such as that he was working "stretched out and sleep deprived," and "will need an Ambien to get some rest."

c. On or about April 6, 2010, while Respondent was working at SMMC, he pulled up the controlled substances of Dilaudid and Fentanyl into a TB syringe, instead of drawing these medications another way. Respondent acted uncomfortable when the charge nurse and another registry nurse were in the medication room with him.

e. On or about April 12, 2010, after Respondent had been removed from SMMC, Respondent called and spoke impolitely and unprofessionally to the hospital's Director of Nursing, accusing the hospital of depriving him of earnings.

f. On or about April 12, 2010, after Respondent spoke to SMMC's Director of Nursing, Respondent emailed CSS. Using some profanity, he dismissed SMMC's investigation of the narcotics wasting incident. Respondent wrote about his financial troubles, and he wrote that he was suicidal soon after the incident, with "a full bottle of whiskey and with my Marine issue knife in my right hand at the ready to be plunged into my heart . . . ."

g. On or about October 28, 2010, Respondent was arrested for domestic violence of another travel nurse, whom he had physically abused and with whom he had lived briefly.

h. As part of Respondent's application to work as a registry nurse for Supplemental Health Care, on or about October 25, 2010, Respondent filled out a Health Statement/Release. Although a list of prescription medications were noted on a physician "Progress Note," there was no mention of any prescription for medical marijuana use on his pre-employment physical, and it was reported that Respondent had no history of smoking, even though Respondent was issued a 12-month marijuana prescription on or about March 24, 2010. Moreover, a drug test taken on November 3, 2010 had negative results for multiple controlled substances, even though

Respondent admittedly used medicinal marijuana and also admittedly used the prescription controlled substances of Clonazepam and Ambien that were being sent by his mother.

i. On or about November 12, 13 and/or 14, 2010, while Respondent was working at LCM, Respondent told other nurses about his troubled past, relationship troubles, struggles with post-traumatic stress disorder and alcoholism, including his prior daily Vodka drinking. Respondent also disappeared many times during his work shift, including when not on break and after he had been told to remain in his assigned work area. Respondent falsely told an LCM staffer that a woman dressed in scrubs had left LCM, when in fact the woman was in Respondent's car; Respondent had been seen periodically with this woman in the lobby since the beginning of his shift. LCM staff members were concerned that the woman, who did not work at LCM, was on drugs, and that Respondent was bringing something to her. Further, Respondent's pupils were dilated, his breath smelled of marijuana, and he appeared to be very fidgety and anxious, exhibiting paranoid and scattered behavior. Respondent's patient care was delayed, including being behind in laboratory draws. Because of Respondent's poor work performance, for which he received an unsatisfactory evaluation from LCM, inappropriate behavior and failure to conduct himself per company policy and procedure, Respondent was told to leave LCM, and he was terminated by Supplemental Health Care.

j. On or about November 12, 13 or 14, 2010, while Respondent was on duty at LCM, Respondent was told to notify other nurses to cover his patients after he left LCM, but he failed to do so.

k. On or about March 9, 2011, Respondent arrived late to his 1845 (i.e., 6:45 p.m.) shift, at about 1915 (i.e., 7:15 p.m.), to HPMC, where Respondent was working as a registry nurse on the night shift. As a result of Respondent being late, he was unable to properly receive the report from the nurse who was going off duty. Additionally, when the charge nurse questioned him about his tardiness, he had an angry outburst. Because of his behavior, gestures, tone and yelling, he appeared to be under the influence of drugs. He accordingly was told to leave, and was removed from patients' service at about 0030 (i.e., 12:30 a.m.) on March 10, 2011.

l. On or about March 9, 2011, prior to Respondent leaving work at HPMC, he failed to transfer one of his two patients from Medical Intensive Care Unit (MICU) 12, where Respondent was assigned, to Cardiac Intensive Care Unit (CICU) 5.

m. Because of Respondent's attitude problems and his not working well with others, Procel Nursing Services, which was the nursing registry company that arranged for Respondent to work at HPMC, terminated Respondent's employment.

FIFTH CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

25. Respondent is subject to disciplinary action under Code sections 2750 and 2761, subdivision (a)(4), in that Respondent was the subject of disciplinary action in other states. The circumstances are as follows:

a. On or about January 25, 2006, in a prior disciplinary action entitled "In the Matter of the Renewal Application for Professional Nurse License No. RN 110724," Arizona State Board of Nursing Case No. 0502091, the Arizona State Board of Nursing adopted a Consent Agreement with Respondent, and entered a disciplinary Order.

b. On or about March 27, 2001, the Nevada State Board of Nursing issued the disciplinary action of an Order of Denial.

DISCIPLINE CONSIDERATIONS

26. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant refers to and incorporates all the allegations contained in paragraph 25 above, subparagraphs (a) and (b), inclusive, as though set forth fully. In addition, Complainant alleges that the Arizona State Board of Nursing's Order required Respondent to obey all federal, state and local laws, and Respondent's Consent Agreement with the Arizona State Board of Nursing included the following findings of fact:

a. Respondent's 2005 license renewal application failed to disclose a complaint and 2001 investigation by the Maryland Board of Nursing.

b. On or about April 11, 2005, Respondent submitted an employment application to Access Nurses, San Diego, California, and, in this application, Respondent falsely denied having

action taken against his professional license, and falsely stated that he received a Masters Nursing degree from the University of Phoenix, when in fact he never was a student of that university.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 590524, issued to Respondent James C. Arthur;

2. Ordering Respondent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: November 1, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
State of California
Complainant

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